DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/06/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155745	B. WING	B. WING			/05/2013
NAME OF PROVIDER OR SUPPLIER HOLY CROSS VILLAGE AT NOTRE DAME INC				STREET ADDRESS, CITY, STATE, ZIP CODE 54515 SR 933 N NOTRE DAME, IN 46556			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	FIX (EACH CORRECTIVE ACTION SH			(X5) COMPLETION DATE
F 000	F 000 INITIAL COMMENTS		F	000			
	This visit was for a Licensure Survey.	Recertification and State					
	Survey dates: May and 5, 2013.	28, 29, 30, 31 and June 3, 4,					
	Facility number: 00: Provider number: 1 AIM number: 20032	55745					
	Survey team: Shelly Vice, RN TC Shauna Carlson, R Julie Baumgartner,	N					
	Census bed type: SNF: 13 NF: 17 SNF/NF: 3 Residential: 41 NCC: 9 Total: 83						
	Census payor type: Medicare: 8 Medicaid: 7 Other: 68 Total: 83						
	Sample: Residential sample: NCC sample: 2	7					
	be in compliance w B and 410 IAC 16.2	at Notre Dame was found to ith 42 CFR Part 483, Subpart in regard to the State Licensure Survey.					
ABORATORY	I DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNATUF	RE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER HOLY CROSS VILLAGE AT NOTRE DAME INC (XA) 10 PREFEX TAG FOOD Continued From page 1 Quality Review 06/05/13 by Lisa McColly DATE DATE STREET ADDRESS, CITY, STATE, 2IP CODE SASS S RS N NOTRE DAME, IN 46556 NOTRE DAME, IN 46556 ID PROVIDER'S BLAN OF CORRECTION PROFIX (EACH OR SECTION AD STORE AD THE APPROPRIATE DEFICIENCY) FOOD Continued From page 1 Quality Review 06/05/13 by Lisa McColly	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
HOLY CROSS VILLAGE AT NOTRE DAME INC SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY OR LSC IDENTIFYING INFORMATION) F 000 Continued From page 1 F 000 F 000 Continued From page 1 F 000 F 000			155745	B. WING			06/05/2013		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 000 Continued From page 1 F 000					54515 SR 933 N				
	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	SHOULD BE COMPLETION		
	F 000			F	000				